# FALL INCIDENT REPORT

(This tool is only an example. Please adapt it to meet the needs of your facility and residents.)

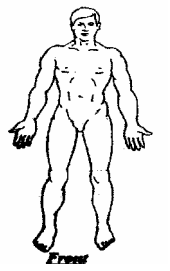
**MR #** _____ **Last Name** _____ **First Name** _____ **Room #** _____
**Date** _____ **Time** _____ **am/pm** □ **Resident** □ **Employee** □ **Visitor**
**Type of Incident** (Check)**:** □ **Fall** □ **Behavior** □ **Other** (Specify)**:**
_____
_____

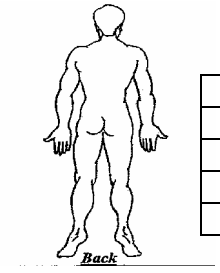
**Physical Assessment:**
**If fall what position was person found in?** (Describe in detail)**:** _____
_____
_____

**Describe mobility or range-of-motion of extremities following incident:** _____
_____
_____

**Is assessed mobility or range-of-motion ability a change?** (Check)**:** □ **No** □ **Yes** (Describe)**:** _____
_____

**Injury** (Check): □ None □ Laceration □ Skin Tear □ Abrasion □ Hematoma □ Swelling □ Other
(Describe and Locate on Diagram): _____




**Vital Signs:**
B/P Lie _____ Temp _____
B/P Sit _____ Pulse _____
B/P Stand ___ Resp _____

**Other:**
BG Accu Check_____
Pulse Oximetry _____
Neuro Checks _____

**Treatment** (Check All That Apply)
□ Examined at Hospital: _____ □ Admitted to Hospital: _____
□ Xray Done (Results): _____ □ First Aid Administered: _____
_____
_____

**Name of Person(s) Administering Treatment:** _____

**Physician Notified:** _____ **Time:** _____ **am/pm Response Time:** _____ **am\pm**

**Family/Other Notified:** _____ **Time:** _____ **am/pm Response Time:** _____**am/pm**

**(Complete Reverse at the Time of Incident)**

**Investigation**

**Exact Location of Incident** (Check)**:** □ Resident's Room □ Hallway □ Bathroom □ Nursing Station □ Lobby □ Shower Room □ Dining Room □ Other (Specify room ##: hallway, bathroom, shower etc.)

□ Incident Witnessed **Name of Witness:** _____
**Address of Witness:** _____

□ Incident Un-Witnessed **Name of Person Who Discovered Incident:** _____

**Description of Incident:** _____
_____

**Person(s) Involved, Statements About Incident:** _____
_____
_____

**What Was the Involved Person Attempting To Do:** □ Getting Out of Bed □ Standing Still □ Wheeling in W/C □ Walking □ Reaching for Object □ Transferring To/From Chair or W/C □ Going to the Bathroom □ Need for Dry Incontinent □ Other (Specify): _____

**Equipment Involved:** □ Walker □ Cane/Crutch □ Wheelchair □ W/C Wheels Locked □ W/C/Wheels Unlocked □ Geri-Chair □ G/C Back Reclined □ G/C Back Upright □ G/C Wheels Locked □ G/C Wheels Unlocked □ Bed □ Half Bedrails □ Full Bedrails □ Bedrails Up □ Bedrails Down □ No Bedrails □ Other (Specify): _____

**Environment:** □ Wet Floor □ Wet Floor Sign in Place □ No Sign □ Object on Walkway □ Poor Lighting □ Rug in Walkway □ Clutter in Walkway □ Foot Ware (Specify) _____ □ New Admit □ Recent Room Move □ Call Light in Reach □ Call Light Not in Reach □ Bed/Chair Alarm On □ Bed/Chair Alarm Off

**Diagnosis or Conditions** □ Vision Deficit □ Hearing Deficit □ Hx of Falls □ Hypotension □ CVD □ Cognitive Deficit □ Wt. Loss □ Dehydration □ Hx CVA □ New Fx □ Parkinson's □ SOB □ Hypertension □ Diabetes □ Neuropathy □ ↓ in ADL's □ Other (Specify): _____

**Medications:** □ Diuretic □ Antidepressant □ Hypnotic □ Anti-anxiety □ Antipsychotic □ Cardiovascular □ Medication Chg. □ 9+ Medications □ Other (Specify): _____

**Why Did This Incident Occur?** (In Your Opinion): _____
_____

**What Was Done Immediately?** (To Prevent Reoccurence): _____
_____

**Name of Person(s) Completing Report:** _____
_____

**REVIEW SIGNATURES:**

**Administrator** _____ **Date** _____ **DON** _____ **Date**_____

**QI** _____ **Date** _____ **Med. Director** _____ **Date** _____